DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-4277 (05/03)

STATE OF WISCONSIN
42 CFR483.420(a)(2)
HSS 134.31(3)(o)
HSS 94.03 & 94.09
s.51.61(1)(g) & (h)

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 9/1/2004

Completion of this form is voluntary. If not completed, the medication cannot be administered without a court order unless in an emergency. This consent is maintained in the client's record and is accessible to authorized users.

Name – Patient / Client (Last, First, MI)	ID Number	Living Unit	Birthdate

Name – Individual Preparing This Form	Name – Staff Contact	Name / Telephone Number – Institution

MEDICATION CATEGORY	MEDICATION	RECOMMENDED DAILY TOTAL DOSAGE RANGE	ANTICIPATED DOSAGE RANGE
Antipsychotic/antidepressant	Symbyax (Olanzapine + Fluoxetine)	Once Daily at evening beginning at 6mg/25mg capsule. 18mg/75mg capsule maximum	

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.
Recommended daily total dosage range of manufacturer, as stated in *Physician's Desk Reference* (PDR) or another standard reference.
This medication will be administered ☐ Orally ☐ Injection ☐ Other – Specify:

1. **Reason for Use of Psychotropic Medication and Benefits Expected (note if this is 'Off Label' Use)**
   Include DSM IV diagnosis or the diagnostic "working hypothesis".

2. Alternative mode(s) of treatment other than or in addition to medications include
Note: Some of these would be applicable only in an inpatient environment.

☐ -Environment and / or staff changes
☐ -Positive redirection and staff interaction
☐ -Individual and / or group therapy
☐ -Rehabilitation treatments / therapy (OT, PT, AT)
☐ -Treatment programs and approaches (habilitation)
☐ -Use of behavior intervention techniques

Other Alternatives:

3. Probable consequences of NOT receiving the proposed medication are

Impairment of ☐ -Work Activities ☐ -Family Relationships ☐ -Social Functioning

Possible increase in symptoms leading to potential

☐ -Use of seclusion or restraints
☐ -Limits on access to possessions
☐ -Limits on personal freedoms
☐ -Limit participation in treatment and activities
☐ -Limits on recreation and leisure activities
☐ -Intervention of law enforcement authorities
☐ -Risk of harm to self or others

Other consequences

Note: These consequences may vary, depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

See Page 2

Medication : Symbyax- (Olanzapine + Fluoxetine)

4. Possible side effects, warnings and cautions associated with this medication are listed below. This is not an all inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text such as the PDR or the United States Pharmacopoeia Dispensing Information (USPDI). As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects, in order to enhance care and treatment.

Continued – Possible side effects, warnings and cautions associated with this medication.

The most common side effects are: Dizziness, drowsiness, diarrhea, dry moth, increased appetite, weight gain, trouble sleeping, or joint pain.

Check with your doctor immediately if any of these less common side effects occur: black stools, changes in sexual ability, "coffee ground" vomit, easy bruising or bleeding, mental or mood changes.

Although rare, check with your doctor immediately if you experience the following: fever, muscle stiffness, change in the amount of urine, facial or body muscle twitching, lip smacking or other uncontrolled movements, tremor, weakness on one side of body, irregular or fast heartbeat, difficulty swallowing, seizures.

This drug may infrequently make your blood sugar level rise, which may cause or worsen diabetes. This high blood sugar can rarely cause serious conditions. Tell your doctor immediately if you develop symptoms of high blood sugar, such as increased thirst and urination, or vision changes.

Males: In the very unlikely event you have a painful, prolonged erection, stop using this drug and seek immediate medical attention.

See PDR, USPDI or US Hospital Formulary Service for all-inclusive list of side effects.

By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client's social worker, case manager or psychologist.
4. I have the right to request a review at any time of my record, pursuant to ss. 51.30(4)(d) or 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client's social worker, case manager or agency / facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the **anticipated dosage range** without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s) and the probable consequences, which may occur if the proposed medication is not given.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

SIGNATURES		**DATE SIGNED**
Client – If Presumed Competent to Consent / Parent of Minor / Guardian	Relationship to Client ☐ Self ☐ Parent ☐ Guardian	
Staff Present at Oral Discussion	Title	

Client / Parent of Minor / Guardian Comments